Illinois Department of Public Aid

**REFILL TOO SOON PRIOR APPROVAL WORKSHEET**

_____
TIME

_____ / _____ / _____
DATE OF REQUEST

Provider Name: _____

Pharmacist Name: _____

Provider Phone Number: _____

Provider Identification Number (12 digits): _____

Recipient Name: _____

Recipient Identification Number (9 digits): _____

Date of Service: _____

**********

Drug #1: _____

NDC #: _____

Directions: _____

Quantity: _____

Reason for Request: _____

_____

_____

_____

Last Rx Date: _____

Last Days Supply: _____

Last Quantity: _____

Last Pharmacy: _____

Drug #3: _____

NDC #: _____

Directions: _____

Quantity: _____

Reason for Request: _____

_____

_____

_____

Last Rx Date: _____

Last Days Supply: _____

Last Quantity: _____

Last Pharmacy: _____

Drug #2: _____

NDC #: _____

Directions: _____

Quantity: _____

Reason for Request: _____

_____

_____

_____

Last Rx Date: _____

Last Days Supply: _____

Last Quantity: _____

Last Pharmacy: _____

Drug #4: _____

NDC #: _____

Directions: _____

Quantity: _____

Reason for Request: _____

_____

_____

_____

Last Rx Date: _____

Last Days Supply: _____

Last Quantity: _____

Last Pharmacy: _____

**********

Decision: "P" - No Action: _____ "R" - Approved: _____ Date / By: _____

RPh Called Back / Date / By: _____